STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495394	A. BUILDING _____ B. WING _____	C 03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF BON AIR	9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 3/13/18 through 3/15/18. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 124 certified bed facility was 116 at the time of the survey. The survey sample consisted of 7 current Resident reviews (Residents #1 through #4, and #9-#11) and 4 closed record reviews (Residents #5 through #8).	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide accommodation of resident needs for one of eleven residents in the survey sample, Resident #10. The facility staff failed to ensure Resident #10's call bell (a device with a button that can be pushed to alert staff when assistance is needed) was within the resident's reach. The findings include:	F 558	The Laurels of Bon Air wishes to have this submitted plan of correction stand as its allegation of compliance. Our date of alleged compliance is April 25, 2018. Preparation and/or execution of this plan of correction does not constitute admission to, nor agreement with, either the existence of or the scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan is prepared and/or executed to ensure continuing compliance with regulatory requirements.	4/25/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/05/2018

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F 558	Continued From page 1 Resident #10 was admitted to the facility on 4/2/08. Resident #10's diagnoses included but were not limited to respiratory failure, high blood pressure and a fractured right femur (1). Resident #10's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/8/18, coded the resident's cognition as moderately impaired. Section G coded Resident #10 as requiring extensive assistance of one person with bed mobility. On 3/13/18 at 12:11 p.m., Resident #10 was observed lying in bed with the head of the bed elevated. The resident's call bell was lying on the floor and was not within the resident's reach. When asked if she could reach the call bell, Resident #10 stated, "I don't think so. I haven't tried." On 3/14/18 at 11:13 a.m., an interview was conducted with CNA (certified nursing assistant) #5. CNA #5 was asked where call bells should be placed in relation to residents. CNA #5 stated if a resident is in the bed then the call bell should be within reach, preferably hooked to the sheet. CNA #5 stated if a resident is in the chair then the call bell should be attached to the resident's clothing so hopefully the resident does not go too far to pull the call bell out of the wall. On 3/14/18 at 11:25 a.m., Resident #10 was in a wheelchair approximately three feet in front of the resident's nightstand. The resident's call bell was behind the resident and was lying across the top drawer of the nightstand. The call bell was not within the resident's reach.	F 558	F558 Resident#10 suffered no adverse effects and did not require transfer to a higher level of care. A quality review of current residents call bells has been performed and found to be in reach of all residents. Licensed Nursing Staff re-educated by DON/designee regarding ensuring call bells are in reach for use by residents. DON/designee during morning operational meeting will conduct quality monitoring to ensure call bells are in reach weekdays for 2 weeks, then weekly for 2 weeks. Additional monitoring will be provided during routine facility rounds. Findings to be communicated to the QAPI committee monthly and as indicated. Quality monitoring schedules will be modified based on findings. Additional corrective action or education will be provided as needed.	

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F 558	Continued From page 2 Resident #10's comprehensive care plan dated 8/1/17 failed to document information regarding the call bell. On 3/14/18 at 5:07 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional quality assurance manager) and ASM #4 (the regional manager) were made aware of the above findings. The facility policy titled, "CALL LIGHT" documented, "7. When leaving the room always place the call light within the guest's reach..." No further information was presented prior to exit. (1) The femur is also known as the thighbone. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000166.htm	F 558		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 580		4/25/18

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F 580	Continued From page 3 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to notify the physician of medications not available	F 580	F580 Resident #7 no longer resides in the facility and did not require transfer to a higher level of care during his stay.	

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F 580	Continued From page 4 upon admission for one of 11 residents in the survey sample, Resident # 7. The facility staff failed to notify the physician of scheduled medications not being administered and or available for administration upon Resident # 7's admission to the facility. The findings include: Resident # 7 was admitted on 12/08/17 with diagnoses that included but were not limited to: sepsis (1), intracranial hemorrhage (2), coronary artery disease (3), Parkinson's (4), dementia (5) hypertension (6), hypokalemia (7), hypoxia (8), hyperlipidemia (9), and anemia (10). Resident # 7's most recent MDS (minimum data set), a 5 (five) - day assessment with an ARD (assessment reference date) of 12/15/187 coded Resident # 7 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, 14 being cognitively intact for making daily decisions. Resident # 7 was coded as requiring extensive assistance of one staff member for activities for ADLs (activities of daily living) and supervision with eating. The POS (physician's order sheet) dated 12/08/17 for Resident # 7 documented, "ACTIVE Order 12/08/17 - 12/10/17" Further review of the POS revealed orders for the following medications: - "Nuplazid (13) 17 MG (milligrams) TABLET TWO TAB (tablet) oral once per day (9:00 am) for psychosis with Parkinson's disease noted on 12/08/17 8:26 pm by (Name of Nurse)."	F 580	All new admissions have the potential to affected by this practice, all new admissions from the last 30 days are receiving their medication as ordered. Licensed Nurses will be educated by DON/designee regarding notifying the physician if medication is not available upon admission. Licensed nursing staff will also be educated by DON/designee on Omnicell use for medication availability and stat run/back up pharmacy. DON/designee during morning clinical meeting will conduct quality monitoring of medication availability on new admissions weekdays x4 weeks, and routinely thereafter. Additional corrective action or education will be provided as needed. Findings to be communicated to the QAPI committee monthly and as indicated. Quality monitoring schedules will be modified based on findings.	

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- "Pramipexole (11) 0.5 MG (milligrams) TABLET ONE TAB (tablet) oral (by mouth) three times a daily (9:00 am., 2:00 pm, 9:00 pm) Parkinson's noted on 12/08/17 8:37 pm by (Name of Nurse)."

- "Primidone (12) 50 MG TABLET ONE TAB three times a daily take with meals. Parkinson's (9:00 a.m., 1:00 pm, 5:00 pm) noted on 12/08/17 8:38 pm by (Name of Nurse)."

- "Rytary (14) 48.75 MG - 195 MG CAPSULE TWO CAPS (capsules) before meals and at bedtime (7:30 am, 11:30 am, 4:30 pm, 9:00 pm) Parkinson's noted on 12/08/17 8:41 pm by (Name of Nurse)."

- "Sertraline (15) HCL (hydrochloride) 50 MG TABLET. ONE AND ONE HALF TAB oral one per day (9:00 am) depression noted on 12/08/17 8:44" pm by (Name of Nurse)."

- "Tamsulosin (16) HCL 0.4 MG CAPSULE. TWO CAP oral once per day (9:00 am) bph (benign prostatic hypertrophy) (17) noted on 12/08/17 8:45" pm by (Name of Nurse)."

The eMAR (electronic medication administration record) dated "12-01-17 thru 12-31-17" for Resident # 7 documented the following:

- "Nuplazid 17 MG TABLET TWO TAB oral once per day (9:00 am) for psychosis with Parkinson's disease Start 12/08/17 8:26 pm." Further review of the eMAR for nuplazid documented, (LPN [licensed practical nurse] # 8)'s initials on 12/09/17 at 9:00 a.m. and "(A [absent])" under her initials. The eMAR notes dated 12/01/17 thru 12/31/17 documented, "12-09-17 8:48 am by

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(LPN # 8) NOT HERE."

- "Pramipexole 0.5 MG (milligrams) TABLET ONE TAB (tablet) oral (by mouth) three times a daily (9:00 am., 2:00 pm, 9:00 pm) Parkinson's Start 12/08/17 8:37 pm." Further review of the eMAR for pramipexole documented LPN # 7's initials on 12/08/17 at 9:00 p.m. and "(H [held]) under her initials, LPN # 8's initials on 12/09/17 at 9:00 a.m. and "(A)" under her initials, LPN # 1's initials on 12/09/17 at 2:00 p.m. with "(notes) under her initials. The eMAR notes dated 12/01/17 thru 12/31/17 documented, "12-08-17 09:21 pm (9:21 p.m.) by (LPN # 7) NOT AVAILABLE NEW ADMISSION. MEDS (medications) NOT SENT AT THIS TIME F/ (follow up) [sic] PHARMACY. 12-09-17 08:48 AM (8:48 a.m.) NOT HERE. 12/09/17 04:13 PM (4:13 p.m.) by (LPN # 1) per day shift."

- "Primidone 50 MG TABLET ONE TAB three times a daily take with meals. Parkinson's (9:00 am, 1:00 pm, 5:00 pm) Start 12/08/17 8:38 pm." Further review of the eMAR for primidone documented LPN # 8's initials on 12/09/17 at 9:00 a.m. and "(A)" under her initials, LPN # 8's initials on 12/09/17 at 1:00 p.m. and "(H)" under her initials, LPN # 1's initials on 12/09/17 at 5:00 p.m. with "(H)" under her initials. The eMAR notes dated 12/01/17 thru 12/31/17 documented, "12-09-17 08:48 AM (8:48 a.m.) by (LPN # 8) NOT HERE. 12-09-17 12:41 PM (12:41 p.m.) by (LPN # 8) NOT HERE. 12-09-17 04:43 PM (4:43 p.m.) by (LPN # 1) awaiting pharmacy."

- "Rytary 48.75 MG - 195 MG CAPSULE TWO CAPS (capsules) before meals and at bedtime (7:30 am, 11:30 am, 4:30 pm, 9:00 pm) Parkinson's Start 12/08/17 8:41 pm." Further

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review of the eMAR for Rytary documented, LPN # 8's initials on 12/09/17 at 7:30 a.m., and "(note)" under her initials, LPN # 8's initials on 12/09/17 at 11:30 a.m. and "(note)" under her initials; LPN # 1's initials on 12/09/17 at 4:30 p.m. and 9:00 p.m. with no evidence of any documentation under her initials for 4:30 p.m. and 9:00 p.m. The eMAR notes dated 12/01/17 thru 12/31/17 documented, "12-09-17 08:49 AM (8:49 a.m.) by (LPN # 8) NOT HERE. 12-09-17 12:41 PM (12:41 p.m.) by (LPN # 8) NOT HERE. 12-09-17 12:41 PM (12:41 p.m.) by (LPN # 8) NOT HERE.

- "Sertraline HCL (hydrochloride) 50 MG TABLET. ONE AND ONE HALF TAB oral one per day (9:00 am) depression Start 12/08/17 8:44" pm." Further review of the eMAR for Sertaline documented LPN # 8's initials on 12/09/17 at 9:00 a.m. and "(H)" under her initials. The eMAR notes dated 12/01/17 thru 12/31/17 documented, "12-09-17 08:49 AM (8:49 a.m.) by (LPN # 8) NOT HERE.

- "Tamsulosin HCL 0.4 MG CAPSULE. TWO CAP oral once per day (9:00 am) bph (benign prostatic hypertrophy) Start 12/08/17 8:45 pm." Further review of the eMAR for tamsulosin documented, LPN # 8's initials on 12/09/17 at 9:00 a.m. and "(H)" under her initials. The eMAR notes dated 12/01/17 thru 12/31/17 documented, "12-09-17 08:49 AM (8:49 a.m.) by (LPN # 8) NOT HERE.

Further review of the eMAR notes dated 12/01/17 thru 12/31/17 failed to evidence documentation-evidencing notification to the physician of the following medications: nuplazid, pramipexole, primidone, sertraline and tamulosin not being available for administration or

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administered to Resident #7 as ordered.

Review of the facility's "Omnicell" system (a system by which medication are kept in the facility and are immediately available) revealed Resident # 7's pramipexole, sertraline and tamsulosin were available in the Omnicell system for administration and Resident # 7's medications of nuplazid, primidone, and rytary were not available.

The of (Name of Pharmacy)'s manifest dated 12/08/2017 and 12/010/2017 for Resident # 7 documented the following:

- "Rytary 48.75-195 CAPULE ER (extended release). Date Shipped 12/9/2017. Date Received 12/9/2017. 10:45 PM (p.m.)."

- "Primidone 50 MG TABLET. Date Shipped 12/9/2017. Date Received 12/9/2017. 10:45 PM (p.m.)."

- "Nuplazid 17 MG. Date Shipped 12/9/2017. Date Received 12/9/2017. 10:45 PM (p.m.)."

The nurse's "Progress Notes" dated 12/08/17 through 12/16/17 failed to evidence documentation of notification to the physician or pharmacy, that Resident # 7's medications of rytary, nuplazid, pramipexole, primidonerytary, sertraline and tamulosin were not available at the time of his admission.

On 03/14/18 at 4:45 p.m. ASM (administrative staff member) # 3, regional quality assurance, provided this surveyor with a copy of the codes used on the eMAR. When asked to explain the codes of "(A), (H), (R) and (note), ASM # 3

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stated, "H is held, means the medication was held. R is refused the medication was refused by the resident for whatever reason. A is absent, the resident was not in the facility to receive the medication and note refers to a nurse's note on the eMAR with an explanation. When asked what standard of nursing practice the facility's nurse's follow, ASM # 3 stated, "We follow Lippincott."

On 03/14/18 at 3:30 p.m. and interview was conducted with LPN (licensed practical nurse) # 7 regarding Resident # 7's medications be available on his admission of 12/08/17. When asked if she was the admitting nurse for Resident # 7 on 12/08/17, LPN # 7 stated, "Yes." When asked to describe the procedure for having medications available when a resident is admitted to the facility, LPN # 7 stated, "I fax the doctor's orders to the pharmacy and follow it up with a phone call to the pharmacy to make sure they got the orders. When asked if the physician should have been notified when Resident # 7's medications were not available for administration as ordered, LPN # 7 stated, "No. On a new admission and it depends on the medications."

On 03/15/18 at 7:50 a.m. an interview was conducted with LPN # 1 regarding Resident # 7's medications being available on 12/09/17. When asked to describe the process staff follows when physician ordered medications are not available LPN # 1 stated, "Look in the Omnicell and if not available call the pharmacy. Usually the pharmacy will deliver them in a couple of hours. Notify the physician the medications were not available and what should be done. The physician will make the decision of what to do, maybe substitute or hold the medication. I would also notify the pharmacy and family or RP

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(responsible party) immediately." LPN # 1 was asked to review the eMAR dated 12/01/2017 thru 12/31/17 and the nurse's notes dated 12/08/17 through 12/61/17, for Resident # 7. When asked if the physician was notified of the above medications were not available for administration to Resident #7 as ordered on 12/09/17, LPN # 1 stated no.

On 03/15/18 at 8:15 a.m. a telephone interview was conducted with LPN # 8 regarding Resident # 7's medications not being available on 12/09/17. When asked if the initials (Two Capital Letters) during the 7:00 a.m. to 3:00 p.m. shift documented on the eMAR for Resident # 7 dated 12/09/17, were hers, LPN # 8 stated, "Yes." When asked to describe the process staff follows when physician ordered medications are not available LPN # 8 stated, "I would call the pharmacy and the physician." When asked where physician notification of the medications not being available for administration would be documented, LPN # 8 stated in the nurse's notes. When informed there was no documentation evidencing the physician was notified Resident #7's medications were not available for administration, LPN # 8 could not provide an explanation.

On 03/15/18 at 1:20 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked to describe the process staff follows when a physician ordered medications are not available, ASM # 2 stated, "Follow up with the physician if there is going to be a delay in getting the medications. They should check the Omnicell system for medications on hand. Contact with the physician should be documented in the

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nurse's notes or the 24-hour report. ASM #2 was informed of the concern that Resident # 7's medications were not available for administration as documented above. ASM #2 was informed a review of the eMAR dated "12-01-17 thru 12-31-17 and the nurse's notes dated 12/08/17 thru 12/16/17 did not document notification to the physician or pharmacy. ASM # 2 did not comment but stated she would check the 24 hour report for Resident # 7 from 12/08/17 through 12/16/17.

On 03/15/18 at 4:25 p.m. ASM # 2, director of nursing informed this surveyor they were unable to locate any documentation of the 24 hour reports that the physician or pharmacy were notified of the medication not being available for Resident # 7.

Fundamentals of Nursing Lippincott Williams and Wilkins 2007 page 185
"...make sure you record ...any omission or withholding of a drug for any reason and notify the prescriber."

On 03/15/18 at approximately 4:35 ASM (administrative staff member) # 1 administrator, and ASM # 2, director of nursing were made aware of the above finding.

No further information was provided prior to exit.

Complaint deficiency

References:
(1) Sepsis is an illness in which the body has a severe, inflammatory response to bacteria or other germs. The symptoms of sepsis are not caused by the germs themselves. Instead,

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chemicals the body releases cause the response. This information was obtained from the website: https://medlineplus.gov/ency/article/000666.htm.

(2) Bleeding in the brain caused by the breaking (rupture) of a blood vessel in the head. This information was obtained from the website: http://pacificschoolserver.org/med/ency/article/000796.htm.

(3) A common type of heart disease. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html.

(4) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

(5) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(6) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(7) Low potassium level is a condition in which the amount of potassium in the blood is lower than normal. This information was obtained from the website: https://medlineplus.gov/ency/article/000479.htm.

(8) Deficiency of oxygen reaching the tissues of the body. This information was obtained from the

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website:
https://www.merriam-webster.com/dictionary/hypoxia.

(9) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm.

(10) Low iron. This information was obtained from the website:
https://www.nlm.nih.gov/medlineplus/anemia.html.

(11) Used alone or with other medications to treat the symptoms of Parkinson's disease (PD; a disorder of the nervous system that causes difficulties with movement, muscle control, and balance), including shaking of parts of the body, stiffness, slowed movements, and problems with balance. Pramipexole is also used to treat restless legs syndrome (RLS; a condition that causes discomfort in the legs and a strong urge to move the legs, especially at night and when sitting or lying down). Pramipexole is in a class of medications called dopamine agonists. It works by acting in place of dopamine, a natural substance in the brain that is needed to control movement. This information was obtained from the website:
https://medlineplus.gov/druginfo/meds/a697029.html.

(12) Used alone or with other medications to control certain types of seizures. Primidone is in a

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class of medications called anticonvulsants. It works by decreasing abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682023.html.

(13) Pimavanserin is used to treat hallucinations and delusions in people with psychosis from Parkinson's disease (PD; a disorder of the nervous system that causes difficulties with movement, muscle control, and balance). Pimavanserin is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a616032.html.

(14) Levodopa and carbidopa is used to treat the symptoms of Parkinson's disease and Parkinson's-like symptoms that may develop after encephalitis (swelling of the brain) or injury to the nervous system caused by carbon monoxide poisoning or manganese poisoning. Parkinson's symptoms, including tremors (shaking), stiffness, and slowness of movement, are caused by a lack of dopamine, a natural substance usually found in the brain. Levodopa is in a class of medications called central nervous system agents. It works by being converted to dopamine in the brain. Carbidopa is in a class of medications called decarboxylase inhibitors. It works by preventing levodopa from being broken down before it reaches the brain. This allows for a lower dose of levodopa, which causes less nausea and vomiting. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601068.h

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tml.

(15) Used to treat depression, obsessive-compulsive disorder (bothersome thoughts that won't go away and the need to perform certain actions over and over), panic attacks (sudden, unexpected attacks of extreme fear and worry about these attacks), posttraumatic stress disorder (disturbing psychological symptoms that develop after a frightening experience), and social anxiety disorder (extreme fear of interacting with others or performing in front of others that interferes with normal life). It is also used to relieve the symptoms of premenstrual dysphoric disorder, including mood swings, irritability, bloating, and breast tenderness. Sertraline is in a class of antidepressants called selective serotonin reuptake inhibitors (SSRIs). It works by increasing the amounts of serotonin, a natural substance in the brain that helps maintain mental balance. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697048.html.

(16) Used in men to treat the symptoms of an enlarged prostate (benign prostatic hyperplasia or BPH) which include difficulty urinating (hesitation, dribbling, weak stream, and incomplete bladder emptying), painful urination, and urinary frequency and urgency. Tamsulosin is in a class of medications called alpha blockers. It works by relaxing the muscles in the prostate and bladder so that urine can flow easily. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a698012.html.

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F 580	Continued From page 16 (17) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.	F 580		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of	F 657	F657 Resident #6 no longer resides in this	4/25/18

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F 657	Continued From page 17 complaint investigation, it was determined that the facility staff failed to review and revise the comprehensive care plan for one of eleven residents in the survey sample, Resident #6. The facility staff failed to review and revise Resident #6's comprehensive care plan following multiple falls in October 2017. The findings include: Resident #6 was admitted to the facility on 10/4/17. Resident #6's diagnoses included but were not limited to high blood pressure, diabetes and anxiety disorder. Resident #6's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/11/17, coded the resident as cognitively intact. Section J documented Resident #6 sustained a fall in the last two to six months prior to that admission. Resident #6 discharged from the facility 11/29/17. Review of Resident #6's clinical record and facility investigations revealed the resident fell on the following dates: -10/19/17 -10/26/17 -Twice on 10/28/17 -10/29/17 -Twice on 10/30/17 -10/31/17 Review of Resident #6's comprehensive care plan with an onset dated on 3/21/17 and re-admission care plan dated 10/4/17 failed to reveal evidence that the facility staff reviewed or revised the care plan following all the above falls	F 657	facility. A quality review of care plan interventions for residents with falls has been performed and care plans were updated as needed. Licensed nurses re-educated by DON/Designee regarding following and updating comprehensive care plans following all incidents and accidents. DON/designee during morning clinical meeting to conduct quality monitoring of incident and accident care plans weekdays for 2 weeks, then weekly for 2 weeks. Findings will be communicated to the QAPI committee monthly and as indicated. Quality monitoring schedules will be modified based on findings. Additional corrective action or education will be provided as needed.	

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F 657	Continued From page 18 except for the fall on 10/31/17. On 3/15/18 at 7:54 a.m., an interview was conducted with RN (registered nurse) #5 (the MDS coordinator). RN #5 was asked if a resident's care plan should be updated after each fall. RN #5 stated, "Yes." RN #5 stated care plans are not updated if a resident is sent out and admitted to the hospital because a new care plan will be developed when the resident returns. RN #5 was asked if the care plan should be updated if a resident is sent to the emergency room but is not admitted to the hospital and returns to the facility. RN #5 stated, "It should get updated." Note- Resident #6 was sent to the emergency room on 10/28/17 and 10/29/17 but was not admitted to the hospital and returned to the facility. On 3/15/18 at 8:20 a.m. Resident #6's falls and care plans were reviewed with RN #5 and ASM (administrative staff member) #2 (the director of nursing). RN #5 confirmed there was no documentation to evidence Resident #5's care plan was reviewed and revised following the falls from 10/19/17 through 10/30/17. RN #5 stated she knew the staff reviewed and revised the care plan but could not provide evidence of this. On 3/15/18 at 1:45 p.m. ASM #2, ASM #3 (the regional quality assurance manager) and ASM #4 (the regional manager) were made aware of the above findings. No further information was presented prior to exit.	F 657		
F 658	COMPLAINT DEFICIENCY Services Provided Meet Professional Standards	F 658		4/25/18

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F 658 SS=D	Continued From page 19 CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, clinical record review, and during the course of a complaint investigation, it was determined that the facility staff failed to follow professional standards of quality for three of eleven residents in the survey sample, Residents #2 #11 and #7. 1. The facility staff administered insulin to Resident #2 against physician order on 12/13/17. The order documented to give insulin after meals only if the resident ate greater than 50 percent. On 12/16/17, Resident #2 ate 50 percent of her lunch and insulin was administered. 2. The facility staff failed to accurately transcribe Resident #11's physician order for a cranberry capsule. 3a. The facility nurse documented on the EMAR (electronic medication administration record) medications that were administered by another nurse on a different shift for Resident # 7. 3b The facility staff failed to obtain physician ordered blood pressures every shift for Resident # 7. The findings include:	F 658	F658 Resident #2's insulin order has been discontinued. Resident #11's order for cranberry capsules has been clarified. Resident #7 no longer resides in this facility. Resident #2, #11 and #7 did not require transfer to a higher level or care and did not sustain any adverse effects. All residents receiving sliding scale insulin orders and cranberry capsules have the potential to be affected by this practice. Licensed nursing staff to be educated by DON/Designee on following physician orders and documentation on the EMAR (electronic medication administration). A quality review of physician orders for insulin, cranberry capsules and BP monitoring has been performed. DON/designee during morning clinical meeting will conduct quality monitoring of insulin orders, cranberry capsule orders and BP monitoring orders weekdays for 2 weeks, then weekly for 2 weeks. Findings to be communicated to the QAPI committee monthly and as indicated. Quality monitoring schedules will be modified based on findings. Additional	

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F 658	Continued From page 20 1. The facility staff administered insulin to Resident #2 against physician order on 12/13/17. The order documented to give insulin after meals only if the resident ate greater than 50 percent. On 12/16/17, Resident #2 ate 50 percent of her lunch and insulin was administered. Resident #2 was admitted to the facility on 6/24/09 and readmitted on 3/30/11. Resident #2's diagnoses included but were not limited to high blood pressure, diabetes and anxiety disorder. Resident #2's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 2/23/18, coded the resident's cognition as severely impaired. Review of Resident #2's clinical record revealed a physician's order dated 10/16/17 that documented an order for Humalog insulin (1) to be given based on a sliding scale (a certain amount of insulin given based on the resident's blood sugar). The order further documented, "give after meals only if ate >50%." Review of Resident #2's meal intake for lunch on 2/13/17 revealed the resident ate 50 percent. Review of Resident #2's December 2017 eMAR (electronic medication administration record) revealed that on 12/13/17 the resident's blood sugar was 312 at 2:00 p.m. and three units of insulin was administered to Resident #2 although the resident only ate 50 percent. Resident #2's comprehensive care plan dated 3/5/18 documented, "BLOOD SU (SUGAR): At risk for fluctuation blood sugars R/T (Related To): Diabetes, Medication side effects, Psychotropic drug use...Administer medication per orders..."	F 658	corrective action or education will be provided as needed	

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On 3/14/18 at 1:08 p.m., Resident #2's Humalog insulin order was reviewed with LPN (licensed practical nurse) #4 (the nurse who administered insulin to Resident #2 on 12/13/17 at 2:00 p.m.). LPN #4 was asked to explain how the order should be followed. LPN #4 stated, "Depending on how much she eats, whether or not to administer the Humalog." LPN #4 was asked how she was made aware how much Resident #2 ate. LPN #4 stated, "The CNAs (certified nursing assistants) let us know." LPN #4 was asked what should be done if Resident #2 eats 50 percent. LPN #4 stated she would hold the insulin. LPN #4 was shown Resident #2's eMAR and confirmed she administered three units of Humalog insulin to the resident on 12/13/17 at 2:00 p.m. LPN #4 was made aware that according to meal intake documentation, Resident #2 ate 50 percent at lunch on 12/13/17. LPN #4 was asked what should have been done. LPN #4 stated she should have held the insulin but she used her nursing judgement. LPN #4 stated the resident's blood sugar was 312 and she knew the resident's blood sugar would increase so she felt Resident #2 needed the insulin coverage. When asked if she spoke to the physician regarding this, LPN #4 stated she could not recall.

On 3/14/18 at 5:07 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional quality assurance manager) and ASM #4 (the regional manager) were made aware of the above findings.

On 3/15/18 at 8:45 a.m., an interview was conducted with ASM #2. ASM #2 stated the

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previous computer system was programmed where staff could only document meal intake as 25%, 50%, 75% or 100%. ASM #2 stated if Resident #2 ate 55% on 12/13/17 then there was no way for the CNA to document that amount.

On 3/15/18 at 9:42 a.m., an interview was conducted with CNA #6 (the CNA who documented Resident #2's lunch meal intake on 12/13/17). CNA #6 was asked if she was supposed to report Resident #2's meal intake to anyone. CNA #6 stated she has to report the meal intake to the nurse because Resident #2 gets ensure (supplement) if she eats less than 50 percent. CNA #6 was asked to describe Resident #2's meal intake. CNA #6 stated sometimes the resident eats good but a lot of time the resident eats ten to fifteen percent. CNA #6 stated Resident #2 eats more dessert. CNA #6 was asked to describe Resident #2's meal intake in December 2017. CNA #6 stated the resident's intake has decreased a little since then but she really could not remember. CNA #6 was asked if she could recall how much Resident, #6 ate during lunch on 12/13/17. CNA #6 stated she could not recall. CNA #6 stated Resident #2 eats meals in the dining room and she (CNA #6) is not stationed in the dining room when she works the day shift. When asked how she knew Resident #2's lunch meal intake on 12/13/17, CNA #6 stated the person stationed in the dining room would have told her how much Resident #2 ate and she would have documented that amount.

On 3/15/18 at 12:54 p.m., another interview was conducted with LPN #4. LPN #4 was asked how she is made aware of Resident #2's meal intake. LPN #4 stated, "Most of the time I go in the dining room to scan through and see who's eating and

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how much." When asked if she observed Resident #2's lunch tray on 12/13/17, LPN #4 stated, "I think I may have seen that she ate 50 percent and I gave her a supplement too." At this time, Resident #2's 12/13/17 2:00 p.m. supplement intake was reviewed with LPN #4. LPN #4 had documented the supplement intake as zero. LPN #4 stated, "I'm sure I might have gave her some."

The facility policy titled, "MEDICATION ADMINISTRATION-SUBCUTANEOUS INJECTION" documented, "Subcutaneous injections will be administered by a licensed nurse at the direction of a physician's order."

The facility standard of practice regarding diabetic management was obtained from the Lippincott website: https://procedures.lww.com/ and documented, "Anti-diabetic agents (insulin or oral anti-diabetic agents) are administered per physician order..."

No further information was presented prior to exit.

(1) Humalog insulin is an injectable medication used to treat diabetes. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697021.html

2. The facility staff failed to accurately transcribe Resident #11's physician order for a cranberry capsule.

Resident #11 was admitted to the facility 6/8/11 and readmitted on 1/3/18. Resident #11's diagnoses included but were not limited to

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congestive heart failure, chronic kidney disease and urinary tract infection. Resident #11's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 1/10/18, coded the resident as cognitively intact.

On 3/14/18 at 8:15 a.m., observation of RN (registered nurse) #2 preparing and administering medications to Resident #11 was conducted. RN #2 removed a container of cranberry capsules 450 mg (milligrams) from the medication cart and placed one capsule in the medication cup. This surveyor confirmed the cranberry capsule was 450 mg with RN #2, and RN #2 stated, "It should be 450 milligrams." Review of Resident #11's March 2018 eMAR (electronic medication record) revealed the following documentation: "CRANBERRY CONCENTRATE 500MG CAPSULE. Give 1 capsule by mouth one time a day for urine prophylactics." A physician's order dated 1/4/18 documented, "CRANBERRY CONCENTRATE 500MG CAPSULE. Give 1 capsule by mouth one time a day for urine prophylactics."

Resident #11's comprehensive care plan dated 1/12/18 documented, "UTI (Urinary Tract Infection): At risk for recurrence of UTI, dehydration and complications 2' (secondary to) co-morbidity...Administer medications per physician order..."

On 3/14/18 at 8:50 a.m., an interview was conducted with (registered nurse) RN #2. RN #2 was made aware Resident #11's eMAR documented to administer 500 mg of cranberry capsule but 450mg was administered and was asked to explain why this occurred. RN #2

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stated, "Whoever put (transcribed/entered) it (the order) in, put in the wrong one. I have to change it." RN #2 stated the standard dose of cranberry capsule was 450 mg. When asked if someone inaccurately transcribed the order and eMAR, RN #2 stated, "Probably."

On 3/14/18 at 5:07 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional quality assurance manager) and ASM #4 (the regional manager) were made aware of the above findings.

On 3/15/18 at 8:45 a.m., ASM #2 confirmed the facility utilized bulk over-the-counter medications (meaning one bottle of medication is used for multiple residents). ASM #2 stated the standard facility physician order for cranberry capsules is for 450 mg. ASM #2 confirmed a transcription error had occurred.

The facility pharmacy policy titled, "4.4 New Orders for Non-Controlled Substances" was the facility standard of practice for physician order transcription. The policy documented, "2.1.2 Facility should ensure medication orders include medication name, strength, dose, route, frequency, indication for use, stop orders, and parameters for administration, if any..."

On 3/15/18, upon this surveyor's entrance into the facility at 7:15 a.m., a physician's order for Resident #11 was sitting on the table in the conference room. The order was dated 3/14/18 and documented, "Cranberry Tablet 450 MG. Give 1 tablet by mouth one time a day for supplement."

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No further information was presented prior to exit.

3a. The facility nurse documented on the eMAR (electronic medication administration record) medications that were administered by another nurse on a different shift for Resident # 7.

Resident # 7 was admitted on 12/08/17 with diagnoses that included but were not limited to: sepsis (1), intracranial hemorrhage (2), coronary artery disease (3), Parkinson's (4), dementia (5) hypertension (6), hypokalemia (7), hypoxia (8), hyperlipidemia (9), and anemia (10).

Resident # 7's most recent MDS (minimum data set), a 5 (five) - day assessment with an ARD (assessment reference date) of 12/15/187 coded Resident # 7 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, 14 being cognitively intact for making daily decisions. Resident # 7 was coded as requiring extensive assistance of one staff member for activities for ADLs (activities of daily living) and supervision with eating.

The POS (physician's order sheet) dated 12/08/17 for Resident # 7 documented, "ACTIVE Order 12/08/17 - 12/10/17" Further review of the POS revealed orders for the following medications and treatment:

- "Voltaren (11) 1% gel. Topically (on top of the body) four times daily (9:00 am, 1:00 pm, 5:00 pm, 9:00 pm) apply to left shoulder. Pain. Noted on 12/08/17."

- "Pramipexole (12) 0.5 MG (milligrams) TABLET ONE TAB (tablet) oral (by mouth) three times a

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daily (9:00 am., 2:00 pm, 9:00 pm) Parkinson's noted on 12/08/17 8:37 pm by (Name of Nurse)."

- "Cephalexin (13) 500 MG CAPSULE. ONE CAP (capsule) oral three times a day (9:00 am, 2:00 pm, 9:00 pm) for 5 (five) days for urinary tract infection. Note 12-08-17."

The eMAR (electronic medication administration record) dated "12-01-17 thru 12-31-17" for Resident # 7 documented the following:

- "Voltaren 1% gel. four times daily topically for pain. Start on 12/08/17." Further review of the eMAR for voltaren documented LPN (licensed practical nurse) # 1's initials on 12/09/17 at 1:00 pm. The eMAR notes dated 12/01/17 thru 12/31/17, documented, "12-09-17 04:13 PM (4:13 p.m.) by (LPN # 1) per day shift."

- "Pramipexole 0.5 MG (milligrams) TABLET ONE TAB (tablet) oral (by mouth) three times a daily (9:00 am., 2:00 pm, 9:00 pm) Parkinson's Start 12/08/17 8:37 pm." Further review of the eMAR for pramipexole documented LPN # 1's initials on 12/09/17 at 2:00 p.m. with the word "(notes)" under her initials. The eMAR notes dated 12/01/17 thru 12/31/17 documented, "12/09/17 04:13 PM (4:13 p.m.) by (LPN # 1) per day shift."

- "Cephalexin 500MG CAPSULE. One cap three times daily for urinary tract infection. Note 12-08-17. Extended Directions: for 5 (five) days." Further review of the eMAR for cephalexin documented LPN # 1's initials on 12/09/17 at 2:00 p.m. with the word "(notes)" under her initials. The eMAR notes dated 12/01/17 thru 12/31/17 documented, "12/09/17 04:13 PM (4:13 p.m.) by

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(LPN # 1) per day shift."

The nurse's "Progress Notes" dated 12/08/17 through 12/16/17 failed to evidence verification that Resident # 7 received the above documented medications on 12/09/17.

On 03/15/18 at 7:50 a.m., an interview was conducted with LPN # 1 regarding Resident # 7's medication administration on 12/09/17. When asked what shift she worked on 12/09/17, LPN # 1 stated, "My shift started at 3:00 p.m." LPN # 1 was asked to review the eMAR (electronic medication administration record) and the eMAR notes dated "12-01-17 thru 12-31-17" for Resident # 7. When asked why her initials were documented on 12/09/17 for the administration of pramipexole and cephalexin at 2:00 p.m. and the treatment of voltaren at 1:00 p.m., LPN # 1 stated, "I saw that it wasn't done (the box was blank). We (nursing) were told to put our initials in and document 'Per day, evening or night shift." When asked if she was present during the previous shift, and witnessed pramipexole, cephalexin and voltaren being administered at 2:00 and 1:00 p.m. on 12/09/17, LPN # 1 stated, "No." When asked if there was documentation that verified she witnessed pramipexole, cephalexin and voltaren administered by the nurse on the previous shift, LPN # 1 stated, "No." When asked to describe the procedure followed when a blank on the eMAR is found, LPN # 1 stated, "Don't sign off on a medication you didn't give. I should have found out if the medication was actually given by contacting the nurse on that shift and then have that nurse document the MAR."

On 03/15/18 at 1:20 p.m., an interview was

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conducted with ASM (administrative staff member) # 2, director of nursing. When asked to describe the procedure for documenting medication administration, ASM # 2 stated, "The nurse reviews the orders on the MAR against the physician's orders, follows the rights of medication administration. After the pass (administering the medication) is done, they document on the MAR by initial or check mark, depending on the system, that the medication was given. After reviewing eMAR (electronic medication administration record) and the eMAR notes dated "12-01-17 thru 12-31-17" for Resident # 7, ASM # 2 was asked if LPN # 1 followed the correct procedure for documenting the administration of pramipexole, cephalexin and voltaren on the eMAR when LPN # 1 did not administer the medications and treatment herself. ASM # 2 stated, "Nurse's should not document anything they don't do."

On 03/15/18 at approximately 4:35 ASM (administrative staff member) # 1 administrator, and ASM # 2, director of nursing were made aware of the above finding.

No further information was provided prior to exit.

Complaint deficiency

References:
(1) Sepsis is an illness in which the body has a severe, inflammatory response to bacteria or other germs. The symptoms of sepsis are not caused by the germs themselves. Instead, chemicals the body releases cause the response. This information was obtained from the website: https://medlineplus.gov/ency/article/000666.htm.

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(2) Bleeding in the brain caused by the breaking (rupture) of a blood vessel in the head. This information was obtained from the website: http://pacificschoolserver.org/med/ency/article/000796.htm.

(3) A common type of heart disease. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html.

(4) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

(5) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(6) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(7) Low potassium level is a condition in which the amount of potassium in the blood is lower than normal. This information was obtained from the website: https://medlineplus.gov/ency/article/000479.htm.

(8) Deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hypoxia.

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(9) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm.

(10) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(11) Used alone or with other medications to treat the symptoms of Parkinson's disease (PD; a disorder of the nervous system that causes difficulties with movement, muscle control, and balance), including shaking of parts of the body, stiffness, slowed movements, and problems with balance. Pramipexole is also used to treat restless legs syndrome (RLS; a condition that causes discomfort in the legs and a strong urge to move the legs, especially at night and when sitting or lying down). Pramipexole is in a class of medications called dopamine agonists. It works by acting in place of dopamine, a natural substance in the brain that is needed to control movement. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697029.html.

(12) Diclofenac topical gel (Voltaren) is used to relieve pain from osteoarthritis (arthritis caused by a breakdown of the lining of the joints) in certain joints such as those of the knees, ankles, feet, elbows, wrists, and hands. Diclofenac topical liquid (Pennsaid) is used to relieve osteoarthritis

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pain in the knees. Diclofenac is in a class of medications called nonsteroidal anti-inflammatory drugs (NSAIDs). It works by stopping the body's production of a substance that causes pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a611002.html.

(13) Used to treat certain infections caused by bacteria such as pneumonia and other respiratory tract infections; and infections of the bone, skin, ears, genital, and urinary tract. Cephalexin is in a class of medications called cephalosporin antibiotics. It works by killing bacteria. Antibiotics such as cephalexin will not work for colds, flu, or other viral infections. Using antibiotics when they are not needed increases your risk of getting an infection later that resists antibiotic treatment. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a682733.html.

3b The facility staff failed to obtain physician ordered blood pressures every shift for Resident # 7.

The POS (physician's order sheet) dated 12/08/17, signed by the physician on 12/11/17 for Resident # 7 documented, "Hydralazine (1) 25 MG (milligram) TABLET. ONE TAB (tablet) oral (by mouth) every 6 (six) hours prn (as needed) sbp (2) [systolic blood pressure] take every 6 hours as needed for sbp > (greater than) 140. Hypertension (high blood pressure). Noted 12/08/17."

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The eMAR (electronic medication administration record) dated 12/01/17 thru 12/31/17 for Resident # 7 documented, "HYDRALAZINE 25 MG TABLET. One tab (tablet) every 6 hours prn (as needed); oral for hypertension. Start 12-08-17 pm. DC (discontinue) 12-12-17 pm." Further review of the eMAR for hydralazine 25 mg from 12/08/17 through 12/12/17 failed to evidence systolic blood pressures were obtained.

The telephone order dated 12/12/17 for Resident # 7 documented, "3. Take B/P (blood pressure) every 6 (six) hrs (hours) if sbp >140 give PRN (as needed) hydralazine 10 mg, po (by mouth) prn."

The eMAR (electronic medication administration record) dated 12/01/17 thru 12/31/17 for Resident # 7 documented, "HYDRALAZINE 10 MG TABLET. One tab every 6 hours prn; oral for hypertension. Start 12-13-17 pm. DC 12-16-17 pm." Further review of the eMAR for hydralazine 10 mg from12/13/17 through 12/16/17 failed to evidence systolic blood pressures were obtained.

On 03/15/18 at 1:00 p.m. an interview was conducted with LPN (licensed practical nurse) # 3 regarding Resident # 7's blood pressures. When asked if the initials (Two Capital Letters) during the 7:00 a.m. to 3:00 p.m. shift documented on the eMAR for Resident # 7 dated 12/12/17 and 12/13/17 were hers, LPN # 3 stated, "Yes." When asked staff document resident's blood pressures, LPN # 3 stated. "In the nurse's notes or on the 24 hour report." After reviewing the eMAR dated 12/01/17 thru 12/31/17 and the nurse's notes dated 12/08/17 through 12/16/17 for Resident # 7, LPN # 3 was asked why Resident # 7's blood pressures were not obtained. LPN # 3 stated, "It was probably over

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looked." When asked how she would be able to determine if Resident # 7 required the hydrazaline if the blood pressure was not being taken according to the physician's orders, LPN # 3 stated you wouldn't."

On 03/15/18 at 1:20 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked where a resident's blood pressure would be documented, ASM # 2 stated, "Blood pressure should be documented on the MAR (medication administration record), nurse's notes or the 24 hour report. After reviewing the eMAR dated 12/01/17 thru 12/31/17 and the nurse's notes dated 12/08/17 through 12/16/17 for Resident # 7, ASM # 2 stated, "I don't see any blood pressures." ASM # 2 stated she would check the 24-hour reports for Resident # 7's blood pressures.

On 03/15/18 at 4:25 p.m. ASM # 2, director of nursing informed this surveyor that they were unable to locate any documentation of the 24 hour reports evidencing Resident # 7's blood pressures were recorded.

On 03/15/18 at approximately 4:35 p.m., ASM (administrative staff member) # 1 administrator, and ASM # 2, director of nursing were made aware of the above finding.

No further information was provided prior to exit.

(1) Hydralazine is used to treat high blood pressure. Hydralazine is in a class of medications called vasodilators. It works by relaxing the blood vessels so that blood can flow more easily

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F 658	Continued From page 35 through the body. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682246.html (2) Blood pressure is the force of your blood pushing against the walls of your arteries. Each time your heart beats, it pumps blood into the arteries. Your blood pressure is highest when your heart beats, pumping the blood. This is called systolic pressure. When your heart is at rest, between beats, your blood pressure falls. This is called diastolic pressure. Your blood pressure reading uses these two numbers. Usually the systolic number comes before or above the diastolic number. This information was obtained from the website: https://medlineplus.gov/highbloodpressure.html	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to ensure treatment and care was provided in accordance with professional standards of practice, the comprehensive person-centered	F 684	F684 Resident #7 no longer resides in this facility. Resident #9's follow-up appointment with the surgeon was scheduled however resident and family elected to cancel the	4/25/18

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F 684	Continued From page 36 plan of care for two of 11 residents in the survey sample, Residents # 7 and # 9. 1a. The facility staff failed to obtain physician ordered blood pressures every six hours for Resident # 7. 1b. The facility staff failed to administered physician ordered medications that were readily available in the facility's Omnicell system (4), to Resident # 7. 2. The facility staff failed to arrange a follow-up surgeon consult for Resident #9 in a timely manner. The findings include: 1a. The facility staff failed to obtain physician ordered blood pressures every six hours for Resident # 7. Resident # 7 was admitted on 12/08/17 with diagnoses that included but were not limited to: sepsis (1), intracranial hemorrhage (2), coronary artery disease (3), Parkinson's (4), dementia (5) hypertension (6), hypokalemia (7), hypoxia (8), hyperlipidemia (9), and anemia (10). Resident # 7's most recent MDS (minimum data set), a 5 (five) - day assessment with an ARD (assessment reference date) of 12/15/187 coded Resident # 7 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, 14 being cognitively intact for making daily decisions. Resident # 7 was coded as requiring extensive assistance of one staff member for activities for ADLs (activities of daily	F 684	appointment. All residents with Physician orders for BP monitoring have the potential to be affected by this practice. A quality review of all residents admitted in the last 30 days has been performed and all appointments have been scheduled. All new admissions have the potential to affected by this practice, all new admissions from the last 30 days are receiving their medication as ordered. Licensed Nurses will be educated by DON/designee regarding notifying the physician if medication is not available upon admission. Licensed nursing staff will also be educated by DON/designee on Omnicell use for medication availability. DON/designee during morning clinical meeting will conduct quality monitoring of medication availability on new admissions daily x4 weeks, and routinely thereafter. Additional corrective action or education will be provided as needed. Findings to be communicated to the QAPI committee monthly and as indicated. Quality monitoring schedules will be modified based on findings. Additional corrective action or education will be provided as needed.	

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living) and supervision with eating.

The POS (physician's order sheet) dated 12/08/17, signed by the physician on 12/11/17 for Resident # 7 documented, "Hydralazine (11) 25 MG (milligram) TABLET. ONE TAB (tablet) oral (by mouth) every 6 (six) hours prn (as needed) sbp (12) [systolic blood pressure] take every 6 hours as needed for sbp > (greater than) 140. Hypertension (high blood pressure). Noted 12/08/17."

The eMAR (electronic medication administration record) dated 12/01/17 thru 12/31/17 for Resident # 7 documented, "HYDRALAZINE 25 MG TABLET. One tab (tablet) every 6 hours prn (as needed); oral for hypertension. Start 12-08-17 pm. DC (discontinue) 12-12-17 pm." Further review of the eMAR for hydralazine 25 mg from 12/08/17 through 12/12/17 failed to evidence systolic blood pressures were obtained.

The telephone order dated 12/12/17 for Resident # 7 documented, "3. Take B/P (blood pressure) every 6 (six) hrs (hours) if sbp >140 give PRN (as needed) hydralazine 10 mg, po (by mouth) prn."

The eMAR (electronic medication administration record) dated 12/01/17 thru 12/31/17 for Resident # 7 documented, "HYDRALAZINE 10 MG TABLET. One tab every 6 hours prn; oral for hypertension. Start 12-13-17 pm. DC 12-16-17 pm." Further review of the eMAR for hydralazine 10 mg from 12/13/17 through 12/16/17 failed to evidence systolic blood pressures were obtained.

On 03/15/18 at 1:00 p.m. an interview was conducted with LPN (licensed practical nurse) # 3 regarding Resident # 7's blood pressures. When

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asked if the initials (Two Capital Letters) during the 7:00 a.m. to 3:00 p.m. shift documented on the eMAR for Resident # 7 dated 12/12/17 and 12/13/17 were hers, LPN # 3 stated, "Yes." When asked staff document resident's blood pressures, LPN # 3 stated. "In the nurse's notes or on the 24 hour report." After reviewing the eMAR dated 12/01/17 thru 12/31/17 and the nurse's notes dated 12/08/17 through 12/16/17 for Resident # 7, LPN # 3 was asked why Resident # 7's blood pressures were not obtained. LPN # 3 stated, "It was probably over looked." When asked how she would be able to determine if Resident # 7 required the hydrazaline if the blood pressure was not being taken according to the physician's orders, LPN # 3 stated you wouldn't."

On 03/15/18 at 1:20 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked where a resident's blood pressure would be documented, ASM # 2 stated, "Blood pressure should be documented on the MAR (medication administration record), nurse's notes or the 24 hour report. After reviewing the eMAR dated 12/01/17 thru 12/31/17 and the nurse's notes dated 12/08/17 through 12/16/17 for Resident # 7, ASM # 2 stated, "I don't see any blood pressures." ASM # 2 stated she would check the 24-hour reports for Resident # 7's blood pressures.

On 03/15/18 at 4:25 p.m. ASM # 2, director of nursing informed this surveyor that they were unable to locate any documentation of the 24 hour reports evidencing Resident # 7's blood pressures were recorded.

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On 03/15/18 at approximately 4:35 p.m., ASM (administrative staff member) # 1 administrator, and ASM # 2, director of nursing were made aware of the above finding.

No further information was provided prior to exit.

References:
(1) Sepsis is an illness in which the body has a severe, inflammatory response to bacteria or other germs. The symptoms of sepsis are not caused by the germs themselves. Instead, chemicals the body releases cause the response. This information was obtained from the website: https://medlineplus.gov/ency/article/000666.htm.

(2) Bleeding in the brain caused by the breaking (rupture) of a blood vessel in the head. This information was obtained from the website: http://pacificschoolserver.org/med/ency/article/000796.htm.

(3) A common type of heart disease. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html.

(4) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

(5) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(6) High blood pressure. This information was

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obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(7) Low potassium level is a condition in which the amount of potassium in the blood is lower than normal. This information was obtained from the website: https://medlineplus.gov/ency/article/000479.htm.

(8) Deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hypoxia.

(9) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm.

(10) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(11) Hydralazine is used to treat high blood pressure. Hydralazine is in a class of medications called vasodilators. It works by relaxing the blood vessels so that blood can flow more easily through the body. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682246.html

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(12) Blood pressure is the force of your blood pushing against the walls of your arteries. Each time your heart beats, it pumps blood into the arteries. Your blood pressure is highest when your heart beats, pumping the blood. This is called systolic pressure. When your heart is at rest, between beats, your blood pressure falls. This is called diastolic pressure. Your blood pressure reading uses these two numbers. Usually the systolic number comes before or above the diastolic number. This information was obtained from the website: https://medlineplus.gov/highbloodpressure.html

1b. The facility staff failed to administered physician ordered medications that were readily available in the facility's Omnicell system (4), to Resident # 7.

The POS (physician's order sheet) dated 12/08/17 for Resident # 7 documented, "ACTIVE Order 12/08/17 - 12/10/17" Further review of the POS revealed in part the following medications orders:

- "Pramipexole (1) 0.5 MG (milligrams) TABLET ONE TAB (tablet) oral (by mouth) three times a daily (9:00 am., 2:00 pm, 9:00 pm) Parkinson's noted on 12/08/17 8:37 pm by (Name of Nurse)."

- "Sertraline (2) HCL (hydrochloride) 50 MG TABLET. ONE AND ONE HALF TAB oral one per day (9:00 am) depression noted on 12/08/17 8:44" pm by (Name of Nurse)."

- "Tamsulosin (3) HCL 0.4 MG CAPSULE. TWO CAP oral once per day (9:00 am) bph (benign prostatic hypertrophy) (5) noted on 12/08/17 8:45"

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pm by (Name of Nurse)."

The eMAR (electronic medication administration record) dated "12-01-17 thru 12-31-17" for Resident # 7 documented the following:

- "Pramipexole 0.5 MG (milligrams) TABLET ONE TAB (tablet) oral (by mouth) three times a daily (9:00 am, 2:00 pm, 9:00 pm) Parkinson's Start 12/08/17 8:37 pm." Further review of the eMAR for pramipexole documented LPN # 7's initials on 12/08/17 at 9:00 p.m. and "(H) under her initials, LPN # 8's initials on 12/09/17 at 9:00 a.m. and "(A [absent])" under her initials, LPN # 1's initials on 12/09/17 at 2:00 p.m. with "(notes) under her initials. The eMAR notes dated 12/01/17 thru 12/31/17 documented, "12-08-17 09:21 pm (9:21 p.m.) by (LPN # 7) NOT AVAILABLE NEW ADMISSION. MEDS (medications) NOT SENT AT THIS TIME F/ (follow up) [sic] PHARMACY. 12-09-17 08:48 AM (8:48 a.m.) NOT HERE. 12/09/17 04:13 PM (4:13 p.m.) by (LPN # 1) per day shift."

- "Sertraline HCL (hydrochloride) 50 MG TABLET. ONE AND ONE HALF TAB oral one per day (9:00 am) depression Start 12/08/17 8:44" pm." Further, review of the eMAR for Sertaline documented LPN # 8's initials on 12/09/17 at 9:00 a.m. and "(H [held])" under her initials. The eMAR notes dated 12/01/17 thru 12/31/17 documented, "12-09-17 08:49 AM (8:49 a.m.) by (LPN # 8) NOT HERE.

- "Tamsulosin HCL 0.4 MG CAPSULE. TWO CAP (capsule) oral once per day (9:00 am) bph (benign prostatic hypertrophy) Start 12/08/17 8:45 pm." Further, review of the eMAR for tamsulosin documented, LPN # 8's initials on 12/09/17 at

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9:00 a.m. and "(H [held])" under her initials. The eMAR notes dated 12/01/17 thru 12/31/17 documented, "12-09-17 08:49 AM (8:49 a.m.) by (LPN # 8) NOT HERE.

Review of the facility's "Omnicell" system (a system by which medication are kept in the facility and are immediately available) revealed Resident # 7's pramipexole, sertraline and tamsulosin were available in the Omnicell system.

On 03/14/18 at 4:45 p.m. ASM (administrative staff member) # 3, regional quality assurance, provided this surveyor with a copy of the codes used on the eMAR. When asked to explain the codes of "(A), (H), (R) and (note), ASM # 3 stated, "H is held, means the medication was held. R is refused the medication was refused by the resident for whatever reason. A is absent, the resident was not in the facility to receive the medication and note refers to a nurse's note on the eMAR with an explanation. When asked what standard of nursing practice the facility's nurse's follow, ASM # 3 stated, "We follow Lippincott."

On 03/14/18 at 3:30 p.m. and interview was conducted with LPN (licensed practical nurse) # 7 regarding Resident # 7's medications administration upon his admission on 12/08/17. When asked if she was the admitting nurse for Resident # 7 on 12/08/17, LPN # 7 stated, "Yes." When asked to describe the procedure for having medications available when a resident is admitted to the facility, LPN # 7 stated, "I fax the doctor's orders to the pharmacy and follow it up with a phone call to the pharmacy to make sure they got the orders. After reviewing the eMAR dated

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"12-01-17 thru 12-31-17" regarding the medication sertraline prescribed for Resident # 7, LPN # 7 was asked if the medication sertraline was available in the facility's Omnicell (4) system. LPN # 7 stated she didn't check.

On 03/15/18 at 7:50 a.m., an interview was conducted with LPN # 1 regarding Resident # 7's medication administration per physician's orders on 12/09/17. When asked to describe the process when a physician ordered medication or medications are not available, LPN # 1 stated, "Look in the Omnicell and if not available call the pharmacy. Usually the pharmacy will deliver them in a couple of hours." LPN # 1 was asked to review the eMAR dated 12/01/2017 thru 12/31/17 and the nurse's notes dated 12/08/17 through 12/61/17, regarding the pramipexole prescribed for Resident # 7. When asked if she checked the facility's Omnicell system for the medication pramipexole, LPN # 1 stated no.

On 03/15/18 at 8:15 a.m., a telephone interview was conducted with LPN # 8 regarding Resident # 7's medication administration on 12/09/17. When asked if the initials (Two Capital Letters) during the 7:00 a.m. to 3:00 p.m. shift documented on the eMAR for Resident # 7 dated 12/09/17 were hers LPN # 8 stated, "Yes." When asked to describe the process when a physician ordered medications are not available LPN # 8 stated, "I would call the pharmacy and the physician." When asked about checking the facility's Omnicell system for sertraline and tamsulosin, LPN # 8 could not say if she checked it or not.

On 03/15/18 at 1:20 p.m., an interview was conducted with ASM (administrative staff

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member) # 2, director of nursing. When asked to describe the process when a physician ordered medication or medications are not available ASM # 2 stated, "The nurse should follow up with the pharmacy by phone to ensure they received the faxed order and when to expect the medications. Follow up with the physician if there is going to be a delay in getting the medications. They should check the Omnicell system for medications on hand."

On 03/15/18 at approximately 4:35 ASM (administrative staff member) # 1 administrator, and ASM # 2, director of nursing were made aware of the above finding.

No further information was provided prior to exit.

Complaint Deficiency

References:

(1) Used alone or with other medications to treat the symptoms of Parkinson's disease (PD; a disorder of the nervous system that causes difficulties with movement, muscle control, and balance), including shaking of parts of the body, stiffness, slowed movements, and problems with balance. Pramipexole is also used to treat restless legs syndrome (RLS; a condition that causes discomfort in the legs and a strong urge to move the legs, especially at night and when sitting or lying down). Pramipexole is in a class of medications called dopamine agonists. It works by acting in place of dopamine, a natural substance in the brain that is needed to control movement. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697029.h

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tml.

(2) Used to treat depression, obsessive-compulsive disorder (bothersome thoughts that won't go away and the need to perform certain actions over and over), panic attacks (sudden, unexpected attacks of extreme fear and worry about these attacks), posttraumatic stress disorder (disturbing psychological symptoms that develop after a frightening experience), and social anxiety disorder (extreme fear of interacting with others or performing in front of others that interferes with normal life). It is also used to relieve the symptoms of premenstrual dysphoric disorder, including mood swings, irritability, bloating, and breast tenderness. Sertraline is in a class of antidepressants called selective serotonin reuptake inhibitors (SSRIs). It works by increasing the amounts of serotonin, a natural substance in the brain that helps maintain mental balance. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697048.html.

(3) Used in men to treat the symptoms of an enlarged prostate (benign prostatic hyperplasia or BPH) which include difficulty urinating (hesitation, dribbling, weak stream, and incomplete bladder emptying), painful urination, and urinary frequency and urgency. Tamsulosin is in a class of medications called alpha blockers. It works by relaxing the muscles in the prostate and bladder so that urine can flow easily. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a698012.html.

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(4) Omnicell medication and Supply Automation System is an automated medication and supply cabinet systems emable remote dispensing needed medications at th point of care. Authorized caregivers can access most medications from the Omnicell medication cabinet, which easily stores up to 700 different items. This information was obtained from the website: https://www.omnicell.com/mts/Products_and_Solutions_For_Pharmacy/Automated_Dispensing_Cabinets.aspx.

(5) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.

2. The facility staff failed to arrange a follow-up surgeon consult for Resident #9 in a timely manner.

Resident #9 was admitted to the facility on 11/14/15 and readmitted on 2/9/18. Resident #9's diagnoses included but were not limited to anxiety disorder, pneumonia and a fractured neck of the left femur (1). Resident #9's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 2/23/18, coded the resident as cognitively intact.

On 3/13/18 at 12:11 p.m. while speaking with Resident #9, the resident verbalized concern that her "stitches" had been left in place for too long.

Review of hospital documentation dated 2/17/18, located in Resident #9's clinical record revealed the following:

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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"A (Assessment): 90 y/o (year old) female with LT (left) femoral neck fx (fracture) s/p (status post) Hemiarthroplasty (2) by (name of surgeon) 2/4/2018...Dispo (Disposition): okay for DC (discharge) once medically cleared by hospitalist. Patient will need to follow up with (name of surgeon) in 2-3 weeks. Please call (phone number) to schedule appointment."

Review of Resident #9's clinical record failed to reveal the follow up appointment with the surgeon had been scheduled or occurred.

A physician's order dated 3/13/18 documented, "Remove staples to left hip..."

Resident #9's comprehensive care plan dated 2/22/18 documented, "Potential for complications from surgical wound. Site: Left Hip. Staples: 21..." The care plan failed to document information regarding follow up appointments with the surgeon.

On 3/13/18 at 2:47 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked when Resident #9's staples were placed. LPN #1 stated the staples were placed at the end of February when Resident #9 fell and had her hip repaired. When asked if the resident had a follow up appointment with the orthopedic surgeon, LPN #1 stated, "No. They never had a return for her." LPN #1 stated she spoke with Resident #9's attending physician and the nurse practitioner on the previous day and they said she could remove Resident #9's staples because they had been in place for almost a month. At this time, LPN #1 was asked to review the hospital documentation in Resident #9's clinical record. LPN #1 confirmed Resident #9

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was readmitted to the facility on 2/9/18 and confirmed nursing staff should have seen the hospital paperwork when the resident was re-admitted. LPN #1 also confirmed Resident #9 had not been seen by the surgeon since readmission. LPN #1 stated she looked at the facility appointment calendar and did not see an appointment for Resident #9. LPN #1 was asked what should be done when a resident is readmitted with the above hospital documentation. LPN #1 stated, "Every instruction should be followed." When asked what prompted her to address Resident #9's staples on the previous day, LPN #1 stated the resident was due for her physician ordered dressing change. LPN #1 stated the area looked very healed and she realized she had been providing treatment for a while so she discussed this with the physician.

On 3/14/18 at 11:10 a.m., observation of Resident #9's left hip surgical site was conducted with the resident's permission. The staples were removed. No concerns were identified with the area.

On 3/14/18 at 5:07 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional quality assurance manager) and ASM #4 (the regional manager) were made aware of the above findings.

On 3/15/18 at 1:10 p.m. ASM #2 stated Resident #9 was readmitted to the facility on 2/9/18 and should have had a follow-up appointment with the surgeon in three weeks from 2/9/18 which corresponded with the date 3/2/18. ASM #2 stated on 3/2/18 Resident #9 presented with upper respiratory issues and was started on

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antibiotic medication. When asked if a follow-up appointment was scheduled for Resident #9 prior to 3/2/18, ASM #2 confirmed an appointment had not been scheduled before that date. When asked the period from when an appointment is made to when the appointment occurs, ASM #2 stated, "That could take some time." When asked when a follow-up appointment for a newly admitted resident should be scheduled, ASM #2 stated the follow-up appointment should be discussed in the daily clinical operations meeting and given to the unit clerk to schedule. When asked when this should occur, ASM #2 stated this should occur upon admission. When asked when Resident #9's orthopedic surgeon follow-up appointment was scheduled, ASM #2 stated the appointment was scheduled on 3/13/18 for this day (3/15/18) but Resident #9's daughter canceled the appointment because the resident was sick.

The facility policy titled, "Report of Consultation" documented, "It is the policy of (name of company) to maintain accurate records of consultations between physicians and to ensure that guests will receive the required physician services to ensure continuity of care in maintaining or improving their mental and physical functional status."

No further information was presented prior to exit.

(1) The femur is also known as the thighbone. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000166.htm

(2) Hemiarthroplasty is hip fracture surgery. This information was obtained from the website:

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F 684	Continued From page 51 https://medlineplus.gov/ency/article/007386.htm	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and in the course of complaint investigation, it was determined that the facility staff failed to provide care and services to prevent accidents for one of eleven residents in the survey sample, Resident #6. The facility staff failed to implement interventions to prevent future falls after Resident #6 fell on 10/28/17 and 10/29/17. The findings include: Resident #6 was admitted to the facility on 10/4/17. Resident #6's diagnoses included but were not limited to high blood pressure, diabetes and anxiety disorder. Resident #6's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 10/11/17, coded the resident as cognitively intact. Section G coded Resident #6 as requiring supervision of one staff for bed mobility and transfers. Section J documented	F 689	Past noncompliance: no plan of correction required.	4/5/18

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Resident #6 sustained a fall in the last two to six months prior to that admission. Resident #6 discharged from the facility 11/29/17.

Review of Resident #6's clinical record and facility fall investigations revealed the resident fell twice on 10/28/17. In regards to the first fall, the facility staff documented a medication review with the pharmacist would be completed (note- the review was completed). In regards to the second fall, a nurse's note dated 10/28/17 at 3:02 p.m. documented Resident #6 was found sitting on the bathroom floor at 12:20 p.m. The resident reported slight left hip and leg pain and was sent to the emergency room. An x-ray in the emergency room revealed no fracture and Resident #6 was sent back to the facility. Further review of the clinical record failed to reveal the facility staff implemented any interventions to prevent future falls. In addition, facility staff presented no fall investigation regarding this fall. A nurse's note dated 10/29/17 documented Resident #6 was observed lying on the floor in front of the toilet. The resident presented with a hematoma (1) to the forehead, "a small cut" to the bridge of the nose and was sent to the emergency room. Dermabond (2) was applied to the bridge of the Resident's nose in the emergency room and the resident was sent back to the facility. Further review of the clinical record and the fall investigation failed to reveal the facility staff implemented any interventions to prevent future falls.

Review of Resident #6's comprehensive care plan with an onset dated on 3/21/17 and re-admission care plan dated 10/4/17 failed to reveal evidence that the facility staff reviewed or revised the care plan following the above falls.

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On 3/15/18 at 7:54 a.m., an interview was conducted with RN (registered nurse) #5 (the MDS coordinator). RN #5 was asked what the facility staff does to address falls and prevent future falls. RN #5 stated the nurses immediately complete an incident packet and implement an intervention. RN #5 stated the interdisciplinary team reviews falls in a daily meeting and decides if another intervention is needed.

On 3/15/18 at 11:32 a.m. ASM (administrative staff member) #2 (the director of nursing) confirmed she could not find the fall investigation regarding Resident #6's second fall on 10/28/17. ASM #2 stated the resident was sent to the hospital and she (ASM #2) could not locate documentation that any intervention to prevent future falls was implemented. In regards to the fall on 10/29/17, ASM #2 stated the resident was sent to the hospital and she (ASM #2) could not locate documentation that any intervention to prevent future falls was implemented.

On 3/15/18 at 11:32 a.m., ASM #2 presented a completed action plan regarding falls. The action plan documented, "(Name of facility) ACTION PLAN: Falls. Final goal date: February 19, 2018.
ACTION TO BE COMPLETED
1. ISSUE IDENTIFICATION: There has been an increase of falls with injury noted on residents in the facility.
2. IDENTIFICATION OF OTHERS POTENTIALLY AT RISK: Residents receiving care at the facility.
3. PROCESS CHANGE TO ENSURE THAT OTHERS ARE NOT AFFECTED BY POTENTIALLY DEFICIENT PRACTICE: Fall risk assessments are being performed on all

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residents in the facility to identify guests with high potential for falls, 10 or above and care plans will be updated accordingly. Residents with high potential for falls, 10 or above will be screened by therapy to ensure appropriate interventions are in place. Residents with high potential for falls will attend a fall focus group for diversional activities to decrease the risk of falls.
4. EDUCATION: ADON (Assistant Director of Nursing)/designee will educate nursing staff on fall management and implementation of interventions.
5. MONITORING: On admission, Nursing management will review all fall risk assessments during the clinical operations meeting to ensure appropriate fall precautions/interventions are in place.
6. QA (Quality Assurance): ALL IDENTIFIED ISSUES RELATED TO FALLS WILL BE REPORTED TO QA COMMITTEE FOR TRENDING AND ANALYSIS MONTHLY..."

ASM #2 also provided documentation to evidence the above actions were completed.
During the survey, no other concerns regarding accidents, safety or supervision were identified.

On 3/15/18 at 1:45 p.m. ASM #2, ASM #3 (the regional quality assurance manager) and ASM #4 (the regional manager) were made aware of the above findings.

No further information was presented prior to exit.

COMPLAINT DEFICIENCY

PAST NON-COMPLIANCE

(1) A hematoma is a collection of blood outside of

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F 689	Continued From page 55 a blood vessel. This information was obtained from the website: https://medlineplus.gov/bleeding.html (2) "DERMABOND ADVANCED Adhesive is a wound closure device that can be used to approximate the skin edges created by surgical incisions and lacerations." This information was obtained from the website: https://www.ethicon.com/na/products/wound-closure/skin-adhesives/dermabond-advanced-topical-skin-adhesive	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide respiratory services per physician orders for one of eleven residents in the survey sample, Resident #9. The facility staff failed to administer Resident #9's nebulizer (1) treatment per physician order on 2/13/18.	F 695	F695 Resident #9 has expired. All residents with orders for medication with nebulizer treatments have the potential to be affected by this practice, and all residents are receiving their nebulizer treatments as ordered. Licensed Nurses re-educated by DON/designee regarding following physician orders requiring use of a	4/25/18

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F 695	Continued From page 56 The findings include: Resident #9 was admitted to the facility on 11/14/15 and readmitted on 2/9/18. Resident #9's diagnoses included but were not limited to anxiety disorder, pneumonia and a fractured neck of the left femur (2). Resident #9's most recent MDS (minimum data set), a 14 day Medicare assessment with an ARD (assessment reference date) of 2/23/18, coded the resident as cognitively intact. On 3/13/18 at 12:11 p.m. while speaking with Resident #9, the resident verbalized concern that she was not receiving her breathing treatments. Review of Resident #9's clinical record revealed a physician's order dated 2/10/18 that documented an order for Duoneb (3) solution 0.5-2.5 milligrams/ 3 milliliters- one dose inhaled orally three times a day for seven days for a cough and shortness of breath. Review of the Duoneb order on Resident #9's February 2018 eMAR (electronic medication administration record) revealed that on 2/13/18 at 5:00 p.m. the nurse documented a "5" that the medication was held and to see the nurse's note. The nurse's note dated 2/13/18 documented, "DuoNeb Solution 0.5-2.5 (3) MG (milligrams)/ 3 ML (milliliters) 1 dose inhale orally three times a day for cough/ SOB (shortness of breath) for 7 Days. Neb equipment not available." Resident #9's comprehensive care plan dated 2/16/18 documented, "RESP (Respiratory): Acute Respiratory Infection: Pneumonia/Bronchitis...Interventions: Administer medications for respiratory infection as ordered..."	F 695	nebulizer machines. DON/designee during morning clinical meeting to conduct quality monitoring of physician orders requiring use of a weekdays for 2 weeks, then weekly for 2 weeks. Findings to be communicated to the QAPI committee monthly and as indicated. Quality monitoring schedules will be modified based on findings. Additional corrective action or education will be provided as needed.	

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On 3/14/18 at 9:47 a.m., an interview was conducted with LPN (licensed practical nurse) #1 regarding access to nebulizer machines. LPN #1 stated a supply room was located on both facility floors and extra nebulizer machines were kept in the supply rooms.

On 3/14/18 at 1:20 p.m., an interview was conducted with RN (registered nurse) #4 (the nurse responsible for administering the nebulizer treatment to Resident #9 on 2/13/18 at 5:00 p.m.). RN #4 stated that on 2/13/18 there was no nebulizer machine in Resident #9's room. RN #4 stated there was no nebulizer machines in his other residents' rooms or in the supply room. RN #4 stated the only nebulizer machine he could locate was in a room with a resident who was on isolation precautions. When asked why a nebulizer machine was not available, RN #4 stated this was the first time a situation like this had occurred for him and maybe the machines were being cleaned. RN #4 confirmed Resident #9 did not receive the physician ordered 5:00 p.m. dose of Duoneb on 2/13/18.

On 3/14/18 at 5:07 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional quality assurance manager) and ASM #4 (the regional manager) were made aware of the above findings.

The facility policy titled, "MEDICATION ADMINISTRATION" documented, "All medications and treatments shall be initiated, administered, and/or discontinued in accordance with written physician orders..."

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F 695	Continued From page 58 No further information was presented prior to exit. (1) A nebulizer is a machine that turns liquid medication into mist. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000006.htm (2) The femur is also known as the thighbone. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000166.htm (3) Duoneb is a combination medication that is inhaled and is used to treat respiratory conditions. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000025.htm	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755		4/25/18

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F 755	Continued From page 59 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint investigation, it was determined that the facility staff failed to ensure medications were available for administration per physician orders for one of 11 residents in the survey sample, Resident # 7. The facility staff failed to ensure Resident # 7's medications of nuplazid, primidone and rytary were available for administration per physician orders upon admission. The findings include: Resident # 7 was admitted on 12/08/17 with diagnoses that included but were not limited to: sepsis (1), intracranial hemorrhage (2), coronary artery disease (3), Parkinson's (4), dementia (5) hypertension (6), hypokalemia (7), hypoxia (8), hyperlipidemia (9), and anemia (10). Resident # 7's most recent MDS (minimum data	F 755	F755 Resident #7 no longer resides in the facility and did not require transfer to a higher level of care during his stay. All new admissions have the potential to affected by this practice, all new admissions from the last 30 days are receiving their medication as ordered. Licensed Nurses will be educated by DON/designee regarding notifying the physician if medication is not available upon admission. Licensed nursing staff will also be educated by DON/designee on Omnicell use for medication availability. Licensed nursing staff will also be educated on contacting the pharmacy when medications have not been received and use of the stat run/back up pharmacy. DON/designee during morning clinical meeting will conduct quality monitoring of medication availability on new admissions weekdays	

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F 755	Continued From page 60	F 755		

set), a 5 (five) - day assessment with an ARD (assessment reference date) of 12/15/187 coded Resident # 7 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, 14 being cognitively intact for making daily decisions. Resident # 7 was coded as requiring extensive assistance of one staff member for activities for ADLs (activities of daily living) and supervision with eating.

The POS (physician's order sheet) dated 12/08/17 for Resident # 7 documented, "ACTIVE Order 12/08/17 - 12/10/17." Further review of the POS revealed in part the following medication orders:

- "Nuplazid (11) 17 MG TABLET TWO TAB oral once per day (9:00 am) for psychosis with Parkinson's disease noted on 12/08/17 8:26 pm by (Name of Nurse)."

- "Primidone (12) 50 MG TABLET ONE TAB three times a daily take with meals. Parkinson's (9:00 am., 1:00 pm, 5:00 pm) noted on 12/08/17 8:38 pm by (Name of Nurse)."

- "Rytary (13) 48.75 MG - 195 MG CAPSULE TWO CAPS (capsules) before meals and at bedtime (7:30 am, 11:30 am, 4:30 pm, 9:00 pm) Parkinson's noted on 12/08/17 8:41 pm by (Name of Nurse)."

The eMAR (electronic medication administration record) dated "12-01-17 thru 12-31-17" for Resident # 7 documented the following:

- "Nuplazid 17 MG TABLET TWO TAB oral once per day (9:00 am) for psychosis with Parkinson's disease Start 12/08/17 8:26 pm." Further review

x4 weeks, and routinely thereafter. Additional corrective action or education will be provided as needed.

Findings to be communicated to the QAPI committee monthly and as indicated. Quality monitoring schedules will be modified based on findings. Additional corrective action or education will be provided as needed.

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THE LAURELS OF BON AIR	9101 BON AIR CROSSINGS DRIVE BON AIR, VA 23235

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of the eMAR for nuplazid documented, (LPN [licensed practical nurse] # 8)'s initials on 12/09/17 at 9:00 a.m. and "(A [absent])" under her initials. The eMAR notes dated 12/01/17 thru 12/31/17 documented, "12-09-17 8:48 am by (LPN # 8) NOT HERE."

- "Primidone 50 MG TABLET ONE TAB three times a daily take with meals. Parkinson's (9:00 am, 1:00 pm, 5:00 pm) Start 12/08/17 8:38 pm." Further review of the eMAR for primidone documented LPN # 8's initials on 12/09/17 at 9:00 a.m. and "(A)" under her initials, LPN # 8's initials on 12/09/17 at 1:00 p.m. and "(H [held])" under her initials, LPN # 1's initials on 12/09/17 at 5:00 p.m. with "(H)" under her initials. The eMAR notes dated 12/01/17 thru 12/31/17 documented, "12-09-17 08:48 AM (8:48 a.m.) by (LPN # 8) NOT HERE. 12-09-17 12:41 PM (12:41 p.m.) by (LPN # 8) NOT HERE. 12-09-17 04:43 PM (4:43 p.m.) by (LPN # 1) awaiting pharmacy."

- "Rytary 48.75 MG - 195 MG CAPSULE TWO CAPS (capsules) before meals and at bedtime (7:30 am, 11:30 am, 4:30 pm, 9:00 pm) Parkinson's Start 12/08/17 8:41 pm." Further review of the eMAR for rytray documented LPN # 8's initials on 12/09/17 at 7:30 a.m. and "(note)" under her initials, LPN # 8's initials on 12/09/17 at 11:30 a.m. and "(note)" under her initials, LPN # 1's initials on 12/09/17 at 4:30 p.m. and 9:00 p.m. with no evidence or any documentation under her initials for 4:30 p.m. and 9:00 p.m. The eMAR notes dated 12/01/17 thru 12/31/17 documented, "12-09-17 08:49 AM (8:49 a.m.) by (LPN # 8) NOT HERE. 12-09-17 08:49 AM (8:49 a.m.) by (LPN # 8) NOT HERE. 12-09-17 12:41 PM (12:41 p.m.) by (LPN # 8) NOT HERE. 12-09-17 12:41 PM (12:41 p.m.) by (LPN # 8) NOT HERE.

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Review of the facility's Omnicell (14) system revealed Resident # 7's medications nuplazid, primidone and rytary were not available.

The of (Name of Pharmacy)'s manifest dated 12/08/2017 and 12/010/2017 for Resident # 7 documented the following:

"Rytary 48.75-195 CAPULE ER (extended release). Date Shipped 12/9/2017. Date Received 12/9/2017. 10:45 PM (p.m.)."

"Primidone 50 MG TABLET. Date Shipped 12/9/2017. Date Received 12/9/2017. 10:45 PM (p.m.)."

"Nuplazid 17 MG. Date Shipped 12/9/2017. Date Received 12/9/2017. 10:45 PM (p.m.)."

On 03/15/18 at 7:50 a.m. an interview was conducted with LPN # 1 regarding Resident # 7's medications being available on 12/09/17. When asked to describe the process when a physician medications are not available, LPN # 1 stated, "Look in the Omnicell (14) and if not available call the pharmacy. Usually the pharmacy will deliver them in a couple of hours. Notify the physician the medications were not available and what should be done. The physician will make the decision of what to do, maybe substitute or hold the medication. I would also notify the pharmacy immediately." LPN # 1 was asked to review the eMAR dated 12/01/2017 thru 12/31/17 and the nurse's notes dated 12/08/17 through 12/61/17 for Resident # 7. When asked if the procedure was followed for the medications rytary, nuplazid and primidone, not being available on 12/09/17, LPN # 1 stated no.

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On 03/15/18 at 8:15 a.m. a telephone interview was conducted with LPN # 8 regarding Resident # 7's medications be available on 12/09/17. When asked if the initials (Two Capital Letters) during the 7:00 a.m. to 3:00 p.m. shift documented on the eMAR for Resident # 7 dated 12/09/17 were hers, LPN # 8 stated, "Yes." When asked to describe the process followed when a physician ordered medications are not available, LPN # 8 stated, "I would call the pharmacy and the physician." When asked where pharmacy notification of Resident # 7's medications of rytary, nuplazid and primidone not being available, would be documented, LPN # 8 stated in the nurse's notes. When informed that there was no documentation evidencing pharmacy notification, LPN # 8 could not provide an explanation. When asked about checking the facility's system of available medications, LPN # 8 could not say if she checked it or not.

On 03/15/18 at 1:20 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked to describe the process followed when a physician ordered medications are not available for administration, ASM # 2 stated, "The nurse should follow up with the pharmacy by phone to ensure they received the faxed order and when to expect the medications. Follow up with the physician if there is going to be a delay in getting the medications. They should check the Omnicell system for medications on hand. Contact with the pharmacy should be documented in the nurse's notes or the 24 hour report. ASM #2 was informed of the above concern regarding medications for Resident # 7 not being available on 12/08/17 and 12/09/17. ASM #2 was informed

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a review of the eMAR dated "12-01-17 thru 12-31-17 and the nurse's notes dated 12/08/17 thru 12/16/17 did not document notification to the pharmacy. ASM # 2 did not comment but stated she would check the 24 hour report for Resident # 7 from 12/08/17 through 12/16/17.

On 03/15/18 at 4:25 p.m. ASM # 2, director of nursing informed this surveyor that they were unable to locate any documentation of the 24 hour reports that the pharmacy was notified of the medication not being available for Resident # 7.

On 03/15/18 at approximately 4:35 ASM (administrative staff member) # 1 administrator, and ASM # 2, director of nursing were made aware of the above finding.

No further information was provided prior to exit.

Complaint Deficiency

References:
(1) Sepsis is an illness in which the body has a severe, inflammatory response to bacteria or other germs. The symptoms of sepsis are not caused by the germs themselves. Instead, chemicals the body releases cause the response. This information was obtained from the website: https://medlineplus.gov/ency/article/000666.htm.

(2) Bleeding in the brain caused by the breaking (rupture) of a blood vessel in the head. This information was obtained from the website: http://pacificschoolserver.org/med/ency/article/000796.htm.

(3) A common type of heart disease. This information was obtained from the website:

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https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html.

(4) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

(5) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(6) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(7) Low potassium level is a condition in which the amount of potassium in the blood is lower than normal. This information was obtained from the website: https://medlineplus.gov/ency/article/000479.htm.

(8) Deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hypoxia.

(9) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm.

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(10) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(11) Used alone or with other medications to control certain types of seizures. Primidone is in a class of medications called anticonvulsants. It works by decreasing abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682023.html.

(12) Pimavanserin is used to treat hallucinations and delusions in people with psychosis from Parkinson's disease (PD; a disorder of the nervous system that causes difficulties with movement, muscle control, and balance). Pimavanserin is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a616032.html.

(13) Levodopa and carbidopa is used to treat the symptoms of Parkinson's disease and Parkinson's-like symptoms that may develop after encephalitis (swelling of the brain) or injury to the nervous system caused by carbon monoxide poisoning or manganese poisoning. Parkinson's symptoms, including tremors (shaking), stiffness, and slowness of movement, are caused by a lack of dopamine, a natural substance usually found in the brain. Levodopa is in a class of medications called central nervous system agents. It works by being converted to dopamine in the brain.

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F 755	Continued From page 67 Carbidopa is in a class of medications called decarboxylase inhibitors. It works by preventing levodopa from being broken down before it reaches the brain. This allows for a lower dose of levodopa, which causes less nausea and vomiting. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601068.html. (14) Omnicell medication and Supply Automation System is an automated medication and supply cabinet systems emable remote dispensing needed medications at the point of care. Authorized caregivers can access most medications from the Omnicell medication cabinet, which easily stores up to 700 different items. This information was obtained from the website: https://www.omnicell.com/mts/Products_and_Solutions_For_Pharmacy/Automated_Dispensing_Cabinets.aspx.	F 755		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility	F 842		4/25/18

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must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

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F 842	Continued From page 69 §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for two of eleven residents in the survey sample, Residents #2 and #7. 1.a. The facility staff failed to document Resident #2's blood sugars and how much insulin was administered to the resident on multiple occasions in December 2017. 1.b. The facility staff failed to document Resident #2's meal intake on multiple occasions in December 2017. 2. The facility staff failed to accurately code Resident # 7's eMAR (electronic medication administration record) for medications that were unavailable. The findings include: 1.a. The facility staff failed to document Resident	F 842	F842 Resident#7 no longer resides in this facility. Resident #2's blood sugars, insulin administration and meal intake is being documented on appropriately. All new admissions have the potential to affected by this practice, all new admissions from the last 30 days are receiving their medication as ordered. All residents with Physician orders for BP monitoring have the potential to be affected by this practice. All residents receiving sliding scale insulin orders have the potential to be affected by this practice. Current residents who receive meals by mouth have the potential to be affected by this practice. Licensed Nurses will be educated by DON/designee regarding blood sugar and insulin documentation, meal intake documentation and EMAR documentation. DON/designee during morning clinical meeting to conduct quality monitoring of insulin orders, blood sugar	

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F 842	Continued From page 70 #2's blood sugars and how much insulin was administered to the resident on multiple occasions in December 2017. Resident #2 was admitted to the facility on 6/24/09 and readmitted on 3/30/11. Resident #2's diagnoses included but were not limited to high blood pressure, diabetes and anxiety disorder. Resident #2's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 2/23/18, coded the resident's cognition as severely impaired. Review of Resident #2's clinical record revealed a physician's order dated 10/16/17 that documented an order for Humalog insulin (1) to be given based on a sliding scale (a certain amount of insulin given based on the resident's blood sugar). The scale was one unit for a blood sugar of 200 to 250, two units for a blood sugar of 251 to 300, three units for a blood sugar of 301 to 350, four units for a blood sugar of 351 to 400, five units for a blood sugar of 401 to 450 and six units for a blood sugar greater than 451. The order further documented, "give after meals only if ate >50%." Resident #2's December 2017 eMAR (electronic medication administration record) documented the above order and documented sections with a time for the insulin to be administered (10:00 a.m., 2:00 p.m. and 7:00 p.m.), an area for the blood sugar to be recorded and an area for the injection site. On 12/7/17 at 10:00 a.m., the nurse documented initials and "note." There was no note. Resident #2's blood sugar was not recorded and there was no documentation as to if the resident was	F 842	documentation, meal intake documentation, insulin administration and EMAR documentation weekdays for 2 weeks, then weekly for 2 weeks. Findings to be communicated to the QAPI committee monthly and as indicated. Quality monitoring schedules will be modified based on findings. Additional corrective action or education will be provided as needed.	

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administered insulin and/or how much.

On 12/7/17 at 7:00 p.m., the nurse documented initials and "note." The note documented a blood sugar of 348 but failed to document how much insulin was administered.

On 12/8/17 at 2:00 p.m., the nurse documented initials and "note." The note documented, "med [medication] given" but did not document Resident #2's blood sugar or how much insulin was administered.

On 12/8/17 at 7:00 p.m., the nurse documented initials and "note." The note documented, "BS (Blood Sugar) 301 ATE 75% OF MEAL." The note failed to document how much insulin was administered.

On 12/9/17 at 10:00 a.m., the nurse documented initials and "note." There was no note. Resident #2's blood sugar was not recorded and there was no documentation as to if the resident was administered insulin and/or how much.

On 12/10/17 at 10:00 a.m., the nurse documented initials and "note." There was no note. Resident #2's blood sugar was not recorded and there was no documentation as to if the resident was administered insulin and/or how much.

On 12/10/17 at 2:00 p.m., the nurse documented initials and "note." The note documented, "med given" but did not document Resident #2's blood sugar or how much insulin was administered.

Review of additional nurses' notes failed to reveal documentation of Resident #2's blood sugars or

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insulin administration on the above dates.

On 3/14/18 at 1:08 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 was asked where residents' blood sugars are documented. LPN #4 stated she documents blood sugars on the MAR (medication administration record) and report sheet. When asked if residents' blood sugars and the amount of sliding scale insulin given should be documented, LPN #4 stated, "Yeah. More than likely."

On 3/14/18 at 4:02 p.m., an interview was conducted with LPN #5, (a nurse who cared for Resident #2 on some of the above dates). LPN #5 was asked where residents' blood sugars should be documented. LPN #5 stated, "Under the accuchecks (blood sugar checks)." When asked if he meant on the MAR, LPN #5 stated, "Yes." LPN #5 was made aware Resident #2's blood sugars and the amount of insulin administered to the resident were not always documented on the MAR. LPN #5 stated, "Well Yes. I'm not sure. We were on the other (computer) system. It was different than PCC (the current computer system). Now everything pops up but that didn't happen then." LPN #5 stated he did document the blood sugars, for Resident #2, how much insulin was given, if any was given, on report sheets.

On 3/14/18 at 4:08 p.m. an interview was conducted with ASM (administrative staff member) #2 (the director of nursing) and ASM #3 (the regional quality assurance manager). ASM #2 and ASM #3 stated report sheets are tools handed off each shift. ASM #2 and ASM #3 confirmed report sheets are not part of residents'

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clinical records.

On 3/14/18 at 5:07 p.m., ASM #1 (the administrator), ASM #2, ASM #3 and ASM #4 (the regional manager) were made aware of the above findings.

The facility document titled, "DOCUMENTATION GUIDELINES" failed to document information regarding blood sugar and insulin documentation.

No further information was presented prior to exit.

(1) Humalog insulin is an injectable medication used to treat diabetes. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697021.html

1.b. The facility staff failed to document Resident #2's meal intake on multiple occasions in December 2017.

Review of Resident #2's December 2017 ADL (activities of daily living) data report revealed a section for staff to document the resident's breakfast, lunch and dinner intake for each day. Further review of the data report revealed staff failed to document meal intake on the following days:
12/1/17- breakfast, lunch and dinner
12/2/17- breakfast, lunch and dinner
12/3/17- dinner
12/4/17- breakfast and lunch
12/5/17- breakfast, lunch and dinner
12/7/17- breakfast, lunch and dinner
12/8/17- breakfast, lunch and dinner
12/9/17- breakfast, lunch and dinner
12/10/17- breakfast, lunch and dinner

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12/11/17- breakfast, lunch and dinner
12/14/17- breakfast and lunch
12/15/17- breakfast and lunch
12/16/17- dinner
12/17/17- dinner
12/19/17- breakfast, lunch and dinner
12/20/17- breakfast, lunch and dinner
12/21/17- breakfast, lunch and dinner
12/22/17- dinner
12/23/17- breakfast and lunch
12/24/17- breakfast and lunch
12/25/17- breakfast, lunch and dinner
12/26/17- breakfast, lunch and dinner
12/27/17- breakfast and lunch
12/28/17- breakfast, lunch and dinner
12/29/17- breakfast, lunch and dinner
12/31/17- dinner

On 3/14/18 at 2:18 p.m., an interview was conducted with CNA (certified nursing assistant) #5. CNA #5 was asked if staff was supposed to document resident meal intakes. CNA #5 stated, "Yes we do." CNA #5 stated he documents meal intakes and snack intakes for each residents' meal on his shift and documents this in the ADL [activities of daily living] records.

On 3/14/18 at 5:07 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), ASM #3 (the regional quality assurance manager) and ASM #4 (the regional manager) were made aware of the above findings.

The facility document titled, "DOCUMENTATION GUIDELINES" failed to document information regarding meal intake documentation.

No further information was presented prior to exit.

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2. The facility staff failed to accurately code Resident # 7's eMAR (electronic medication administration record) for medications that were unavailable.

Resident # 7 was admitted on 12/08/17 with diagnoses that included but were not limited to: sepsis (1), intracranial hemorrhage (2), coronary artery disease (3), Parkinson's (4), dementia (5) hypertension (6), hypokalemia (7), hypoxia (8), hyperlipidemia (9), and anemia (10).

Resident # 7's most recent MDS (minimum data set), a 5 (five) - day assessment with an ARD (assessment reference date) of 12/15/187 coded Resident # 7 as scoring a 14 on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, 14 being cognitively intact for making daily decisions. Resident # 7 was coded as requiring extensive assistance of one staff member for activities for ADLs (activities of daily living) and supervision with eating.

The POS (physician's order sheet) dated 12/08/17 for Resident # 7 documented, "ACTIVE Order 12/08/17 - 12/10/17" Further review of the POS revealed orders for the following medications:

"Nuplazid (13) 17 MG TABLET TWO TAB oral once per day (9:00 am) for psychosis with Parkinson's disease noted on 12/08/17 8:26 pm by (Name of Nurse)."

"Pramipexole (11) 0.5 MG (milligrams) TABLET

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ONE TAB (tablet) oral (by mouth) three times a daily (9:00 am., 2:00 pm, 9:00 pm) Parkinson's noted on 12/08/17 8:37 pm by (Name of Nurse)."

"Primidone (12) 50 MG TABLET ONE TAB three times a daily take with meals. Parkinson's (9:00 am, 1:00 pm, 5:00 pm) noted on 12/08/17 8:38 pm by (Name of Nurse)."

"Rytary (14) 48.75 MG - 195 MG CAPSULE TWO CAPS (capsules) before meals and at bedtime (7:30 am, 11:30 am, 4:30 pm, 9:00 pm) Parkinson's noted on 12/08/17 8:41 pm by (Name of Nurse)."

"Sertraline (15) HCL (hydrochloride) 50 MG TABLET. ONE AND ONE HALF TAB oral one per day (9:00 am) depression noted on 12/08/17 8:44" pm by (Name of Nurse)."

"Tamsulosin (16) HCL 0.4 MG CAPSULE. TWO CAP oral once per day (9:00 am) bph (benign prostatic hypertrophy) (17) noted on 12/08/17 8:45" pm by (Name of Nurse)."

The eMAR (electronic medication administration record) dated "12-01-17 thru 12-31-17" for Resident # 7 documented the following:

- "Nuplazid 17 MG TABLET TWO TAB oral once per day (9:00 am) for psychosis with Parkinson's disease Start 12/08/17 8:26 pm." Further review of the eMAR for nuplazid documented, (LPN [licensed practical nurse] # 8)'s initials on 12/09/17 at 9:00 a.m. and "(A [absent])" under her initials. The eMAR notes dated 12/01/17 thru 12/31/17 documented, "12-09-17 8:48 am by (LPN # 8) NOT HERE."

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- "Pramipexole 0.5 MG (milligrams) TABLET ONE TAB (tablet) oral (by mouth) three times a daily (9:00 am, 2:00 pm, 9:00 pm) Parkinson's Start 12/08/17 8:37 pm." Further review of the eMAR for pramipexole documented LPN # 8's initials on 12/09/17 at 9:00 a.m. and "(A)" under her initials. The eMAR notes dated 12/01/17 thru 12/31/17documented, "12-09-17 08:48 AM (8:48 a.m.) NOT HERE."

- "Primidone 50 MG TABLET ONE TAB three times a daily take with meals. Parkinson's (9:00 am, 1:00 pm, 5:00 pm) Start 12/08/17 8:38 pm." Further review of the eMAR for primidone documented LPN # 8's initials on 12/09/17 at 9:00 a.m. and "(A)" under her initials. The eMAR notes dated 12/01/17 thru 12/31/17 documented, "12-09-17 08:48 AM (8:48 a.m.) by (LPN # 8) NOT HERE."

Review of the facility's nursing "Progress Notes" dated 12/08/17 through 12/16/17 revealed Resident # 7 was in the facility on 12/09/17.

On 03/14/18 at 4:45 p.m. ASM (administrative staff member) # 3, regional quality assurance, provided this surveyor with a copy of the codes used on the eMAR. ASM #3 was asked to explain the codes of "(A), (H), (R) and (note). ASM # 3 stated, "H is held, means the medication was held, R is refused, the medication was refused by the resident for whatever reason, A is absent, the resident was not in the facility to receive the medication and note refers to a nurse's note on the eMAR with an explanation.

On 03/15/18 at 8:15 a.m. a telephone interview was conducted with LPN # 8, regarding Resident # 7's medications be available on 12/09/17.

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When informed of the eMAR coding of "(A), (H) and (R); "H" is held, means the medication was held, "R" is refused, the medication was refused by the resident for whatever reason, and "A" is absent, the resident was not in the facility to receive the medication, LPN # 8 agreed. When asked if the initials (Two Capital Letters) during the 7:00 a.m. to 3:00 p.m. shift documented on the eMAR for Resident # 7 dated 12/09/17 were hers, LPN # 8 stated, "Yes." When informed of the coding on the December 2017 eMAR for Resident # 7 under her initials on 12/09/17 was coded "A" for the administration of nuplazid, pramipexole and primidone, LPN # 8 stated, "It's coded correctly."

On 03/15/18 at 1:20 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. After reviewing the meanings of the eMAR codes "H, R and A" and reviewing the December 2017 eMAR for Resident # 7, ASM # 2 agreed the coding of the letter "A" for the administration of nuplazid, pramipexole and primidone was inaccurate.

On 03/15/18 at approximately 4:35 ASM (administrative staff member) # 1 administrator, and ASM # 2, director of nursing were made aware of the above finding.

No further information was provided prior to exit.

References:
(1) Sepsis is an illness in which the body has a severe, inflammatory response to bacteria or other germs. The symptoms of sepsis are not caused by the germs themselves. Instead, chemicals the body releases cause the response. This information was obtained from the website:

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https://medlineplus.gov/ency/article/000666.htm.

(2) Bleeding in the brain caused by the breaking (rupture) of a blood vessel in the head. This information was obtained from the website: http://pacificschoolserver.org/med/ency/article/000796.htm.

(3) A common type of heart disease. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/coronaryarterydisease.html.

(4) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

(5) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(6) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(7) Low potassium level is a condition in which the amount of potassium in the blood is lower than normal. This information was obtained from the website: https://medlineplus.gov/ency/article/000479.htm.

(8) Deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hyp

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oxia.

(9) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm.

(10) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html .

(11) Used alone or with other medications to treat the symptoms of Parkinson's disease (PD; a disorder of the nervous system that causes difficulties with movement, muscle control, and balance), including shaking of parts of the body, stiffness, slowed movements, and problems with balance. Pramipexole is also used to treat restless legs syndrome (RLS; a condition that causes discomfort in the legs and a strong urge to move the legs, especially at night and when sitting or lying down). Pramipexole is in a class of medications called dopamine agonists. It works by acting in place of dopamine, a natural substance in the brain that is needed to control movement. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697029.html.

(12) Used alone or with other medications to control certain types of seizures. Primidone is in a class of medications called anticonvulsants. It works by decreasing abnormal electrical activity

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in the brain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682023.html.

(13) Pimavanserin is used to treat hallucinations and delusions in people with psychosis from Parkinson's disease (PD; a disorder of the nervous system that causes difficulties with movement, muscle control, and balance). Pimavanserin is in a class of medications called atypical antipsychotics. It works by changing the activity of certain natural substances in the brain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a616032.html.

(14) Levodopa and carbidopa is used to treat the symptoms of Parkinson's disease and Parkinson's-like symptoms that may develop after encephalitis (swelling of the brain) or injury to the nervous system caused by carbon monoxide poisoning or manganese poisoning. Parkinson's symptoms, including tremors (shaking), stiffness, and slowness of movement, are caused by a lack of dopamine, a natural substance usually found in the brain. Levodopa is in a class of medications called central nervous system agents. It works by being converted to dopamine in the brain. Carbidopa is in a class of medications called decarboxylase inhibitors. It works by preventing levodopa from being broken down before it reaches the brain. This allows for a lower dose of levodopa, which causes less nausea and vomiting. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601068.html.

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(15) Used to treat depression, obsessive-compulsive disorder (bothersome thoughts that won't go away and the need to perform certain actions over and over), panic attacks (sudden, unexpected attacks of extreme fear and worry about these attacks), posttraumatic stress disorder (disturbing psychological symptoms that develop after a frightening experience), and social anxiety disorder (extreme fear of interacting with others or performing in front of others that interferes with normal life). It is also used to relieve the symptoms of premenstrual dysphoric disorder, including mood swings, irritability, bloating, and breast tenderness. Sertraline is in a class of antidepressants called selective serotonin reuptake inhibitors (SSRIs). It works by increasing the amounts of serotonin, a natural substance in the brain that helps maintain mental balance. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697048.html.

(16) Used in men to treat the symptoms of an enlarged prostate (benign prostatic hyperplasia or BPH) which include difficulty urinating (hesitation, dribbling, weak stream, and incomplete bladder emptying), painful urination, and urinary frequency and urgency. Tamsulosin is in a class of medications called alpha blockers. It works by relaxing the muscles in the prostate and bladder so that urine can flow easily. This information was obtained from the website: https: https://medlineplus.gov/druginfo/meds/a698012.html.